STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. BUILDING _____ B. WING _____	C 04/28/2009

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PINNACLE REHABILATATION & HEALTH CENTER	3034 SOUTH DUPONT HIGHWAY SMYRNA, DE 19977

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F 000	INITIAL COMMENTS An unannounced annual survey and complaint visit was conducted at this facility from April 15, 2009 through April 28, 2009. The deficiencies contained in this report are based on observation, staff interviews, and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred and one hundred forty-nine (149). The survey sample totaled twenty-four (24) residents which included a review of twenty-one (21) active and three (3) closed residents' clinical records. There was a sub-sample of ten (10) residents for general observations, interviews, accounting review and medication pass review.	F 000		
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS AND SERVICES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those	F 156	F 156 A) Pinnacle Rehab and Health Center corrected this deficient practice on April 20, 2009 by adding additional information to the admission packet. (See attach.) B) All residents admitted to this facility have the potential to be affected by this deficient practice. C) An audit will be completed for the next 15 incoming admissions to assure compliance with new procedure. D) Results of this audit will be presented to the quality assurance committee for the next two consecutive quarters.	6/18/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rhonda Clear, BS, NHA | TITLE: Administrator | (X6) DATE: 5/25/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	Continued From page 1 other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a	F 156		

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F 156	Continued From page 2 complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on review of the admission package and staff interview, the facility failed to inform the residents in writing, prior to or upon admission, of their legal rights that includes the protection of personal funds. Findings include:	F 156		

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F 156	Continued From page 3 Review of the facility admission package on 4/15/09 and 4/17/09 revealed that the facility failed to inform residents in writing at the time of admission about how their personal funds are protected if residents opted to use that service provided by the facility. The facility used a surety bond to protect resident ' s funds. Interview with admissions director (E32) on 4/17/09 confirmed this finding. On 4/20/09, procedures and forms developed to address this concern were included in the admissions package and implemented that day.	F 156		
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in	F 157	F-157 A) Resident identified no longer resides in the facility. B) Residents with a change in condition have the potential to be affected by this deficient practice. C) Policy and guidelines for notifying physicians of a change in condition have been reviewed and updated to insure that the needs of the resident are being met timely and the physician is being given an accurate reflection of the changes in condition the resident is experiencing. Nursing staff have been in-serviced on the new policy and guidelines for physician notification. Nursing	6/18/09

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F 157	Continued From page 4 resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R24) out of 24 residents the facility failed to consult with the physician when a resident became lethargic, stopped eating and taking medications and had minimal fluid intake. Findings include: Cross refer F327. R24 stopped eating and drank only 300 cc of fluid between 12/19 and 12/22/08. During this time the resident became more lethargic and could not take medication. The nurse practitioner (NP), E26 visited on 12/19/08 to write a discharge home order for 12/24/08 at the request of the family. The facility's Guideline for Notifying Physician's/Nurse Practitioners of Clinical Problems indicated that a resident with a rapid decline or continued instability would require immediate physician notification. Review of the record and interview with staff revealed that no contact was made with the physician or his designee between E26's visit on 12/19 and being sent to the emergency room on 12/22/08. The resident was admitted with dehydration.	F 157	management will review the 24 hour report daily to insure that licensed staff are notifying the physician of changes in condition and the physician is responding back with orders within time frames established in the policy guidelines. All changes in condition will be reviewed in morning meeting to insure there has been appropriate follow through on all changes. An in-service will be given on all licensed staff on recognizing a change and condition and how to properly report this to the physician. D) • A weekly audit x 4 weeks will be completed on 5 residents on each unit with a change in condition for 4 weeks and then monthly for 3 months. Audits will be reviewed during the monthly QA/QI meeting and modified and or continued as needed.	6/18/09

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F 159 SS=B	483.10(c)(2)-(5) PROTECTION OF RESIDENT FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the	F 159	F159 A) Pinnacle Rehab and Health Center corrected this deficient practice on 4/20/09. B) All residents have the potential to be affected by this deficient practice. C) An audit will be completed will be completed for the next 15 incoming admissions to assure compliance with new procedure. D) Results of the audit will be presented at the next two consecutive QA meetings.	

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F 159	Continued From page 6 SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on review of the admissions package and interview with admission personnel (E32), it was determined that the facility failed to obtain written authorization from the residents when the facility held, and managed personal funds of the resident deposited with the facility. Findings include: Review of the admissions package on 4/17/09 with the admissions director (E32) lacked written documentation of the refund policy for residents' personal funds, and a personal fund authorization form that allowed the facility to manage the residents' funds. Monthly accounting and quarterly statements were being furnished to the residents and the residents' families or representatives. Interview with the admissions director (E32) on 4/17/09, revealed the two items were missing from the admissions package and other facility documentation. On 4/20/09, a procedure and a personal fund authorization form for the facility to manage residents' funds were implemented to address this concern and included in the admissions package.	F 159		
F 160 SS=B	483.10(c)(6) CONVEYANCE UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey	F 160	F160 A) The facility corrected this deficient practice on 4/20/09. All residents identified were refunded their money.	

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F 160	Continued From page 7 within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of resident funds information, it was determined that the facility failed to convey resident funds within 30 days to the resident's family or designated person upon resident's death or departure from facility. Findings include: Resident funds review and staff interviews revealed that the resident funds for three of nine Medicaid residents (SSR4, SSR5, SSR6) were not conveyed to the resident's family or designated person within 30 days. Review of the admissions package on 4/16/09 revealed a lack of refund information. Interview with the admissions director (E32) on 4/17/09 on refunds of personal funds revealed their incorrect practice is to refund resident funds after 60 days. Resident fund accounts were reviewed on 4/20/09. SSR4 had $261.35 in her resident's fund account. The resident expired on 1/29/09. Resident SSR5 had $967.94 in her fund. The resident expired on 11/11/08. SSR6 had $44.08 in her fund. The resident expired on 5/17/08. Admission Director (E32) interview on 4/20/09 whom contacted corporate accounting staff confirmed these findings	F 160	B) Any resident that discharges or expires will be refunded within 30 days. C) A release of resident funds acknowledgment will be signed upon admission. (Attach) The policy regarding resident funds will be provided upon admission. D) An Audit of the resident funds account will be completed weekly by the Business Office manager 1 x per week x's 4 weeks and will be presented at QA for the next two consecutive quarters.	6/18/09
F 166	483.10(f)(2) GRIEVANCES	F 166	F166 A) Residents SSR1 and SSR10 no longer reside in this facility.	

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F 166 SS=B	Continued From page 8 A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation of one resident room, interviews with staff and resident, and review of resident council meeting minutes it was determined that the facility failed to ensure that resident grievances were addressed and responded to promptly. Findings include: Observation of resident room for SSR1 and SSR10 during the tour on 4/15/09 revealed that there were two TV's in the room but only one of the TV's was on. The reception quality was poor on the TV for SSR10. SSR1 stated that her TV was not working and that she had brought this concern to maintenance and nursing staff two weeks ago without any success. Review of the complaint forms and interview with social service and maintenance staff on 4/21/09 revealed that a complaint was not written at all when it was brought to the attention of maintenance or facility staff. Review of facility procedures on 4/21/09 revealed that the process for complaints included reporting the complaint to the administrator after it was written. Interview with the administrator through the Director of Nursing (E19) confirmed they were unaware of this complaint and no document was ever written up on this complaint.	F 166	B) All residents who submit grievances have the potential to be affected by this deficient practice. C) The Grievance policy and Procedure has been updated to streamline the process. (see attached) The new Policy and Procedure will be reviewed with resident council and staff for implementation by June 18, 2009. D) The new process will be audited by social service for 30 days and the results will be presented in the next two consecutive QA meetings.	6/18/09

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F 166	Continued From page 9 Review of the activity assessment and notes on 4/21/09 for SSR1 revealed that the resident liked to watch TV, and the care plan stated resident "to watch TV as one of her activities". Review of resident council meeting minutes from January through March 2009 revealed that the residents expressed concerns about different types of issues that were still pending after two months. The group interview conducted 4/16/09 during the survey confirmed these concerns.	F 166	F174 A) Resident SSR2 has the ability to speak on private as of 5/20/09. B) All residents able to use the phone have the ability to be affected by this deficient practice. C) An access card was purchased by the facility to allow phone system to be compactable with Cordless phones. Cordless phones were purchased for each unit on 5/20/09.Residents will be notified at the next Resident Council meeting. Resident SSR2 does not prefer this and requested her family be contacted to supply phone in room. D) A random survey of 10 residents will be conducted to assure that they are able to receive private calls. This information will be presented at QA for the next two consecutive quarters.	6/18/09
F 174 SS=B	483.10(k) TELEPHONE The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. This REQUIREMENT is not met as evidenced by: Based on observations, an individual resident interview and the resident group interview, it was determined that the facility failed to provide residents phone access in a private area where calls can be made without being overheard. Findings include: On 4/15/09 and 4/21/09, SSR2 was observed making personal phone calls at the Sierra nurses station. Her conversation could easily be overheard. Interview on 4/21/09 with this resident confirmed that the only place to make a personal phone call was in the hallway at the nurses station and that it was not in a private area. During the resident group interview on 4/16/09, residents stated that if they needed to make a phone call, the only option they had was the nurses station. They confirmed that this location	F 174		

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F 174	Continued From page 10 did not provide them with privacy from being overheard. They stated the facility talked to them about two months ago about getting portable phones but they had not yet obtained them. A pay phone was observed in the front lobby during the survey, however the area lacked privacy. Interviews with nursing staff at all nurses stations revealed that residents could make phone calls at the nurses station. Interview with the social service director (E33) revealed residents can make phone calls from her office. Interview with the administrator (E18) on 4/21/09 revealed that they ordered portable phones on March 9, 2009 and the bill was due on March 24, 2009. On 4/21/09, the portable phones were not at the facility. On 4/21/09, the administrator (E18) was observed calling the phone company to determine when the phones were going to be delivered and was told that the phones were back ordered until the end of May.	F 174		
F 226 SS=D	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of facility personnel files, policies and procedures and interviews, it was determined that the facility failed to implement their policies and procedure for screening employees that included a thorough background investigation for three (3) employees (E1, E2 and E3). There was no record of verification for fingerprinting available	F 226	F226 A. Correction Action All employees did have registries completed by April 22, 2009. Criminal background Investigation on employees identified as E1, E2 and E3. Employee E2 is an employee of Healthcare Services (not Pinnacle). Adult Abuse Registry on employee identified as E3. Child Abuse Registry on employees identified as E3, E8, E10, E11 and E12. B. All employees have the potential to be affected by the deficient practice.	6/18/09

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F 226	Continued From page 11 to Long Term Care for two staff (E1, E2) out of 20 sampled employees. E3 was found on the criminal background check database but not for this facility. Additionally, there was no record of completed Child Protection and Adult Abuse Registry checks for E3. Findings include: Review of the facility's Policy and Procedure entitled "Quality Assurance and Improvement Abuse Prohibition, Screening of Staff " indicated that criminal background checks will be done for all potential employees. Interview with the human resource staff (E22) during the survey revealed that screening is done prior to hire. 1. Employee E1 was hired on 1/7/09. Review of this employee's file on 4/17/09 revealed that a Criminal History Record was not available to Long Term Care. Interview with human resource staff (E22) on 4/17/09 confirmed that E1 had no record of a Receipt/Verification of fingerprinting available. 2. Employee E2 was hired on 4/1/09. Review of this employee's file on 4/17/09 revealed that there was no record of fingerprint receipt on file or information on the criminal database. 3. Employee E3 was hired on 2/19/09. No fingerprint receipt was found on file. The state criminal database did not have a criminal background review done for this employee to work at this facility. Additionally, there was no record of completed Child Protection and Adult Abuse Registry checks for Employee E3. These were subsequently completed 4/17/09. Four other employees (E8, E10, E11, E12) did not have child abuse registry reviews on file.	F 226	C. All new applicants are processed immediately and faxed to the appropriate state agencies on the day of processing. D. Each new applicant will have a personnel audit spread sheet listed with each agency, date sent, date received. This will be checked weekly for 4 weeks. Results will be reported to QA for the next 2 consecutive quarters.	6/18/09

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PINNACLE REHABILATATION & HEALTH CENTER	3034 SOUTH DUPONT HIGHWAY SMYRNA, DE 19977

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F 252 SS=B	483.15(h)(1) ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observations of resident rooms and hallways during the environmental tour of the facility, and staff interviews it was determined that the facility failed to provide a homelike environment as evidenced by odors detected in two resident rooms and the 200 hallway. Findings include: On 4/15/09 at 1:15 PM, an offensive odor was detected in resident room 338. On 4/17/09 at 11:25 AM, an offensive odor was detected in resident room 218. Housekeeping staff (E34) interview revealed the trash full of soiled diapers in the room was the cause of the smell. The exhaust vent was not working in room 218. On 4/15/09 at 2:55 PM, an offensive odor was detected in the hallway outside room 224. Carts with soiled resident clothing, soiled bed linen, and trash were observed outside the room in the hallway. The vent was not working and the hallway was not under negative pressure.	F 252	F 252 A) All identified vents will be repaired by 6/15/09. Aspen and sierra repaired 5/11/09. B) All residents have the potential to be affected by the same deficient practice. An audit of all vents will be conducted by the Maintenance Director by 6/1/09. C) A service contract was signed by NHA on 5/20/09 for annual inspection of vents as needed. D) All vents will be inspected every week x's 1 month and the results will be presented at QA for the next two consecutive quarters. F 253 A) All identified rooms will be repaired by 6/18/09. 1. Repairs to be completed by 6/18/09 2. Radiators will be painted or replaced by 6/18/09. 3. Ceiling tiles will be replaced by 6/18/09.	6/18/09 6/18/09
F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced	F 253		

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F 253	Continued From page 13 by: Based on observations during the environmental tour from 4/15/09 to 4/20/09, and staff interviews, it was determined that the facility failed to provide maintenance and housekeeping services necessary to maintain a sanitary and comfortable interior. Findings include: 1. Scratched, stained or unpainted walls were observed in resident rooms 104, 106, 111, 201, 204, 300, 326, 333, 338. Interview with maintenance staff (E24) revealed that a program to address these issues existed but a written plan could not be provided to the surveyor. Additionally, the wallpaper on the walls of the Sierra tub room, and room 300 were peeling off. 2. Unpainted and chipped ventilation radiators on the walls of resident rooms 117, 119, 310, and 333 were observed throughout the survey. 3. A total of ten (10) stained ceiling tiles were observed: in the Aspen Tub room, the pantry on the Aspen unit, and three in the kitchen above the dishwasher. Additionally, four (4) shower tiles on the floor of the 200 tub room on 4/17/09 were in disrepair. Another eight (8)floor tiles in one shower stall in this same tub room were cracked. Corroded tiles on the floor were observed in the Seaside dining room. 4. The bathroom hand sink was observed in disrepair and cracked in resident room 206. The toilet lid was loose in resident room 103, and the toilet in the Aspen tub room was in disrepair (did not flush properly). 5. A total of two (2) of eight (8) dining room tables were observed to be unsteady or wobbly in the	F 253	4. Identified Rooms will be repaired by 6/18/09. 5. Dining room tables were fixed on 4/20/09. 6. Privacy Curtains will be repaired, washed or replaced by 6/18/09. 7. Hoyer lift was cleaned 4/28/09. 8. Holes in walls will be repaired by 6/18/09. 9. Floor tiles will be replaced by 6/18/09. 10. Closet doors will be repaired by 6/18/09. 11. Trash can liners will be available at all times and will be appropriately placed in trash cans. 12. Exhaust vents were cleaned on 4/28/09 and will be cleaned monthly by management contract. B) Ambassador rounds will be assigned and completed by management staff daily and will be report to appropriate staff. C) Ambassador round will be completed every morning to assist in the identification of issues.	

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F 253	Continued From page 14 main dining room on 4/15/09 at 10:30 AM. Two (2) of seven (7) dining room tables were unsteady or wobbly in the Aspen dining room on 4/15/09 at 10:15 AM. 6. Privacy curtains were observed dirty in resident rooms 104B and 201B. Hooks were off the privacy curtain rod system in resident rooms 201B, 226, and 300, and Aspen tub room, 7. On 4/20/09 at 9:15 AM, a dirty Hoyer lift was observed in the hallway outside room 325. 8. Holes in the walls of the Aspen soiled utility room, Sierra tub room, and one in the floor of the Seaside bath 1 were observed on 4/15/09. 9. Two floor tiles on the wall of resident room 204 were observed missing. The floor around the toilet area of resident room 218 was dirty/stained. 10. Closet doors were observed in disrepair and could not close in resident rooms 310 and 318. The hinges were in disrepair. Interview with housekeeping staff (E23) revealed they needed to be repaired. 11. Plastic liners were observed missing from garbage cans during the environmental tour in the Aspen tub room, 200 unit tub room, and resident rooms 101, 103, 111, 335, and 343, although the liners were observed in the bottom of the trash cans. The trash can in the 200 unit tub room was cracked. 12. Heavy dust or dusty exhaust vents were observed in resident room 111, and the Seaside Bath I.	F 253	An audit will be completed of rooms 1 x per week x's 4 weeks and will be presented to QA for the next two consecutive quarters.	6/15/09
F 278	483.20(g) - (j) RESIDENT ASSESSMENT	F 278	F-278 A) R3, R6, R17, and R21 had their MDS reviewed and corrected MDS's were	

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F 278 SS=E	Continued From page 15 The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to accurately code the Minimum Data Set (MDS) for six (R17, R22, R21, R3, R6, and R10) out of twenty-four (24) sampled residents. Findings include: Cross refer F279 (Examples #1,#2).	F 278	completed to accurately reflect the resident. R22 no longer resides in the facility. B) • All residents have the potential to be affected by this practice. C) • The MDS's of all residents coded with pressure ulcers were reviewed to insure the coding was accurate. The MDS's of any resident exhibiting physical and verbal abuse towards others were also reviewed to insure this behavior was coded appropriately. MDS staff was educated on the appropriate coding of all residents. D) • 5 assessments on each unit will be reviewed monthly for accuracy in relation to wounds, infections, behaviors and diagnosis, times 3 months by the QA nurse. Results of this audit will be brought through the QA/QI process and reviewed for the continued need of education and monitoring. QI's will be reviewed monthly in QA/QI to assess for any trends that may be reflective of in-correct coding.	6/18/09

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F 278	Continued From page 16 1. R17 was admitted to the facility on 12/31/08 with no behaviors noted on the admission MDS dated 01/18/09 other than wandering or resisting care. The latest quarterly MDS dated 4/12/09 reflected the same. Resident R17 began to develop physical and verbally abusive behaviors towards other residents beginning 3/23/09. Despite evidence of abusive behaviors in the clinical record, these were not coded in the MDS dated 4/12/09 Section E. An interview with E28 (MDS Assessor) on 4/22/09 confirmed these findings. 2. R22 was admitted to the facility on 11/14/08 with multiple diagnoses including lung cancer. The admission MDS dated 11/14/08 was not accurately coded with disease diagnoses under Section I. pp. cancer. Failure to accurately code this section resulted in the facility's failure to develop an appropriate plan of care for R22. These findings were confirmed with the E28 on 4/22/09. 3. R21's MDS assessment dated 2/17/09 documented presence of three, stage III ulcer in Section M1. In Section M2, the ulcer was not coded as either pressure or stasis. Review of R21's Wound Assessment sheet from 2/10/09 through 2/16/09 revealed presence of one, stage III pressure ulcer of the sacrum. An interview with the individual coding the above section, E28 on 4/23/09 at 1 PM confirmed that the above MDS was inaccurately coded three, stage III ulcers in Section M1 and in addition, omitted coding the ulcer as pressure in Section M2.	F 278		

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F 278	Continued From page 17 4. R3's MDS assessment dated 2/11/09 documented presence of one, stage II ulcer in Section M1. In Section M2, the ulcer was not coded as either pressure or stasis. Record review lacked evidence of the above stage II ulcer. An interview with E28 on 4/20/09 at 11:20 AM revealed that the above skin impairment was a skin tear, thus, the above MDS inaccurately coded and that the skin tear should have been coded in Section M4, other skin problems or lesions. 5. R6's MDS assessment dated 1/12/09 documented presence of one, stage II ulcer in Section M1. In Section M2, the ulcer was not coded as either pressure or stasis. Record review lacked evidence of the above stage II ulcer. An interview with E28 on 4/20/09 at 11:40 AM revealed that the above skin impairment was a skin tear, thus, the above MDS was inaccurately coded and that the skin tear should have been coded in Section M4, other skin problems or lesions. 6. Review of R10's records revealed that on 3/26/09, the resident had a wound culture of the left ankle which noted the presence of Methicillin resistant staphylococcus aureus (MRSA) infection. R10's MDS assessment dated 4/1/09 failed to include this infection in Section I2.	F 278		

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F 278	Continued From page 18 An interview with E28 on 4/20/09 at 11:20 AM revealed that the above laboratory results were not available at the time of the MDS completion, thus, MDS was not coded for this infection.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to develop a plan of care for an identified need for two (2) residents (R17 and R22) out of twenty-four (24) sampled residents. Findings include: 1. R17 was admitted to the facility on 12/31/08. According to the admission MDS, the last day of	F 279	F-279 A) • Resident R22 no longer resides in the facility. A care-plan was established for R17 that addresses and monitors the behavior of this resident. Resident 17 returned to facility 4/23/09. B) • Other residents with behaviors and no plan of care for these behaviors have the potential to be affected by this practice. C) • A review was completed on all residents with behaviors affecting others to insure a plan of care is in place to address and monitor the behaviors. An audit will be completed monthly by the QA nurse or designee of 5 residents on each unit in relation to behaviors and diagnosis to insure a plan of care is in place. D) • Results of this audit will be reviewed monthly at the QA/QI meeting.	6/18/09

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F 279	Continued From page 19	F 279		

observation period was 01/18/09 and did not reflect any behaviors symptoms exhibited other than wandering and resisting care. A quarterly review MDS dated 04/12/09 reflected the same.

A review of nursing notes revealed from 01/31/09 until 04/17/09, R17 continually took food from other residents food trays with difficulty of redirection. Nurses notes between 3/23/09 and 4/15/09 documented the following behaviors including being belligerent to other residents, picks fights, pushing others residents as well as hitting another resident. On 4/15/09, R17's behaviors escalated and 911 was called. During these behavioral periods, psychotropic medication was employed for behavior control. On 04/06/09 Zyprexa 10 mg. was started and Depakote 250 mg. was increased to 500 mg. at bedtime. On 04/11/09 Depakote was increased again to 750 mg. at bedtime. Ativan was given orally and intramuscularly on nine occasions for agitation beginning on April 1, 2009 through April 17, 2009.

During the time frame from the onset of verbal abusive behavior beginning on 03/23/09 and physical abusive behavior beginning on 04/05/09, there was no care plan to address or monitor the behavior directed towards other residents until 04/15/09. On 04/15/09 a physician order was written for a direct admit to a psychiatric facility for increased behaviors. Two days later on 04/17/09, R12 was transferred to a psychiatric facility for treatment of aggressive behavior.

The facility failed to provide an appropriate plan of care to address the ongoing and increased behaviors of R12 and findings were confirmed by interview with E28 (MDS assessor).

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F 279	Continued From page 20 2. R22 was admitted to the facility on 11/14/08 with multiple diagnoses including lung cancer. A review of the admission MDS dated 11/21/08 revealed under Section I. Disease Diagnoses, pp. cancer was not addressed. R22's care plan reflected that although he had a plan of care for pain management, the pain according to the care plan was related to arthritis. Based on the information inaccurately coded on the MDS, R22's comprehensive care plan was incomplete. On 01/08/09, R22 was place on Hospice and later expired on 01/19/09.	F 279		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to monitor and/or failed to ensure maintenance of fluid restrictions for three (3) residents (R1, R14, R16) out of twenty-four (24) sampled residents. Findings include: 1. R1 was originally admitted to the facility on 5/23/09 with diagnoses including end stage renal disease and was receiving hemodialysis. Review of the April 2009 monthly physician's order sheet (POS) documented an order for 1,000 cc (cubic centimeter) fluid restriction per day.	F 309	F-309 A) Facility notified the physician and responsible party of the potential for fluid imbalance that had occurred with these 3 residents. No adverse outcome was noted because of this deficient practice. C.N.A.s were informed of each of these residents fluid restriction and the potential for fluid imbalance if not followed. Residents were also reminded of the importance of following the physician orders and staff direction in relation to their fluid restrictions. B) All residents with orders for fluid restriction have the potential to be affected by this practice. A review was	

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F 309	Continued From page 21 Observation of resident's breakfast tray on 4/23/09 at 8:45 AM revealed 236 cc milk container and 120 cc of cranberry juice. Review of the R1's "Resident Fluid Restriction Notification/Allocation" form revealed that on the breakfast tray, the resident was allocated 240 cc of fluids. An interview with a staff of the dietary department, E20 on 4/23/09 at 9:30 AM confirmed that the resident was allocated only 240 cc for breakfast. Review of the facility's policy and procedure titled "Fluid Restrictions" revealed that residents on fluid restrictions will be placed on intake and output monitoring. Review of R1's "Intake and Output (I &O) Record" from April 1, 2009 through April 23, 2009 (23 days) revealed that 24 hours I & O records were missing for eight days (4/1/09, 4/2/09, 4/3/09, 4/4/09, 4/5/09, 4/15/09, 4/19/09 and 4/20/09). In addition, on 4/8/09 and 4/13/09, calculation by the surveyor during the survey revealed that the resident received above the 1,000 cc per day restriction by consuming 1,560 cc and 1,790 cc on these dates. Record review lacked evidence that the staff was monitoring the intake or addressing the extra amounts of fluids. An interview with the unit manager, E16 on 4/23/09 at 1 PM confirmed that the facility failed to monitor and ensure R1's fluid restriction. 2. R14 was admitted to the facility on 04/08/08 with multiple diagnoses including congestive	F 309	completed for all residents on fluid restriction in relation to appropriate and consistent monitoring of intake and compliance with an order for fluid restriction. C)• Policy for hydration and fluid intake monitoring was reviewed and revised to better monitor the needs of the resident. New intake monitoring forms were completed to better assist the facility in gathering and monitoring data. In-services were completed for the clinical staff to insure they had an understanding of what fluid restriction is, how it will be monitored, and the use of the new data collection forms. S)• Residents on fluid monitoring will be reviewed weekly in the risk meeting to insure compliance with the use of the monitoring forms and the stated fluid restrictions. An audit will be completed on all residents with fluid restrictions weekly x 4 weeks and then monthly for 3 months.	6/18/09

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F 309	Continued From page 22 heart failure, hypertension and a history of pleural effusion. Record review revealed a physician's order for fluid restriction of 1000cc per day. Facility policy and procedure stated the nurse will write the amount of fluid restriction on the CNA data Flow Sheet to notify direct care staff not to give additional fluids. R14 was care planned accordingly and followed by dietary supporting the fluid restriction. Review of R14's fluid restriction monitoring sheets revealed the appropriate amount of fluid restriction ordered, however, the daily intake of fluids exceeded 1000cc per day for the months of January 2009 through April 2009. An interview with the DON, E19 on 04/23/09 at 11:30 AM confirmed the facility failed to accurately monitor and ensure R14's fluid restriction. 3. R16 was admitted to the facility on 12/23/08 with multiple diagnoses including congestive heart failure, hypertension and a history of pleural effusion. Record review revealed a physician's order for fluid restriction of 1200cc per day. Facility policy and procedure stated the nurse will write the amount of fluid restriction on the CNA data Flow Sheet to notify direct care staff not to give additional fluids. R16 was care planned accordingly and followed by dietary supporting the fluid restriction. Review of R16's fluid restriction monitoring sheets revealed the appropriate amount of fluid restriction ordered, however, the daily intake of fluids exceeded 1200cc per day for the months of December 2008 through April 2009. An interview with the DON, E19 on 04/23/09 at 11:30 AM confirmed the facility failed to accurately monitor and ensure R14's fluid	F 309		

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F 309	Continued From page 23 restriction.	F 309		
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that one (R6) out of 24 sampled residents failed to receive physician ordered supervision for meals . Findings included: R6 had diagnoses which included Huntington's Disease, seizure disorder, and dysphagia. On 4/20/09 at 9 AM, the resident was observed in bed with a breakfast tray on the over the bed table. The resident was sitting up in bed with her head and upper body leaning to the right side and feeding herself. Lunch observation on 4/22/09 at 12:15 PM revealed the resident sitting up in bed with upper body leaning to the right side, and no staff supervision. Record review revealed a diet order in March 2009 for "mechanical soft, chopped meat, regular liquids. Patient (R6) must be upright in most optimal position and remain upright for 30 minutes after meals. Supervision for all meals." An interview with the Speech Therapist (E30) on 4/23/09 at 10:50 AM revealed that due to R6's aspiration risk as well as R6's upper body leaning,	F 312	F-312 A) • Resident identified was evaluated by therapy for positioning and safety while eating. Resident had no adverse effects as a result of having no supervision while eating. Resident requires no supervision after proper positioning. B) • Residents identified as needing supervision while eating have the potential to be affected by this practice. C) • Resident records were reviewed to insure that anyone with orders for positioning requirements while eating and or supervision is receiving these services. C.N.A. kardex's were reviewed and updated when necessary to reflect the ordered amount of supervision and assistance while eating. Staff was in-serviced on the importance of proper positioning and offering supervision and assistance while eating for residents identified.	

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F 312	Continued From page 24 the order for supervision for all meals was necessary. An interview with E16 (unit manager) on 4/23/09 at 11:15 AM confirmed that the facility failed to ensure supervision during the above meals.	F 312	D) • Monitoring for compliance will be achieved by Management observing mealtimes and auditing those residents that require assistance 5 times a week for 4 weeks and than once a week thereafter. Monitoring will be for dinner and lunch time. Therapy will observe meal times in the dining room twice weekly to insure residents are properly positioned at tables. Results of these observations and audits will be brought through the monthly QA/QI process for review.	
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations with facility staff during the environmental tour, it was determined that the facility failed to maintain an environment free from accident hazards as evidenced by resident water temperatures above 110 degrees Fahrenheit (F), unprotected radiators, chemicals and biohazard unlocked and accessible to residents, and doors that were chipped. Findings include: 1. Observations made with the food service director (E21) and housekeeping director (E23) on the tour 4/15/09 at 11:00 AM of the hot water temperatures in resident rooms #106 and #111 hand sinks revealed the temperature to be at 114.4 and 114.9 degrees Fahrenheit respectively. On 4/15/09 at 12:01PM, the hot water temperatures in resident room 310, ADL Suite Therapy room, and the resident room #338 hand sinks revealed the temperature to be at 134.7, 125, and 127.2 degrees Fahrenheit respectively.	F 323	F 323 A) The hot water temperature issues were corrected on 4/16/09. Additionally, hot water heater was repaired 5/11/09. A new Mixing valve installed 5/14/09. Thermostats were repaired 5/12/09. 2. Radiators to be repaired or replaced by 6/18/09.	6/18/09

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F 323	Continued From page 25 Interview with the food service director staff (E21) revealed these temperatures to be hot and a call was made to maintenance (E24) who stated the switch of the hot water tanks was accidentally moved by the contractors when they were doing work in the hot water tank room. On 4/15/09 between 1:30 PM through 2:17 PM, , the hot water temperatures in resident rooms 300, 326, 333, 336, and the Seaside Bath 1 common shower room hand sinks revealed the temperature to be at 131.1, 126.3, 119.6, 123.2, and 131 degrees Fahrenheit respectively. Surveyor requested the maintenance department to be contacted again and temperatures to be lowered to the required temperatures. Housekeeping Director (E23) interview after checking with the maintenance director (E24)revealed that the hot water system had to be drained which would take a while. On 4/16/09 at 7:00 AM, these resident rooms were checked. The hot water temperatures in the rooms were observed to be below 110 degrees Fahrenheit. The administrator (E18) stated the resident hot water temperatures were being monitored every two hours since yesterday. 2. On 4/15/09, the heat/ventilation radiator along the wall of the Aspen tub common shower room, Sierra tub shower room, and Seaside dining room had the element plates exposed and/or corroded as the cover of the unit had been removed. The plates could potentially cut residents or heat could burn residents. E23 confirmed these findings. 3. On 4/15/09 at 11:05 AM, the Sierra dining room had paint bottles in a cabinet that was unlocked and accessible to residents. On 4/15/09 at 12:00 PM, hazardous chemicals such as sanitizers were	F 323	3. A lock has been placed on cabinets as of 5/1/09. 4. Resident doors identified will be sanded, varnished or replaced by 6/18/09. 5. Razors were removed 4/17/09. B) All existing residents have the potential to be affected by the deficient practice. C) Hot water temperatures will be taken daily and temperature will be documented. D) An audit will be conducted 1 x per week x's 4 weeks and results will be presented to QA for the next two consecutive quarters.	6/18/09

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F 323	Continued From page 26 observed in a cabinet under the hand sink in the ADL suite unlocked and accessible to residents. On 4/17/09, the cabinet had the key on the door but was unlocked. Additionally, on 4/20/09 at 9:00 AM, the Seaside biohazard door was cracked open and numerous spray bottles of sanitizers were observed inside the room on the floor and above the rack in the room accessible to residents and unlocked. On 4/17/09 at 2:45 PM, the Aspen soiled utility work area #1 door was observed open and unlocked for at least 10 minutes containing biohazard containers. 4. The doors of resident rooms 130, 333, 338, were chipped with potential for causing splinter hazards to the residents. 5. On 4/17/09 at 11:20 AM, a biohazard waste plastic container with used razors was observed loose and accessible in the Aspen tub room or central bath.	F 323		
F 325 SS=D	483.25(i) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced	F 325	F-325 A) Resident identified has gained weight since this time and is maintaining current weight. Dietitian has reviewed her record and feels interventions are appropriate at this time. B) Residents with a change of condition, that has the possibility to result in weight loss, have the potential to be affected by this practice. C) Policy and guidelines for	

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F 325	Continued From page 27 by: Based on record review it was determined that the facility failed to recognize, evaluate and address the needs of one resident (R4) out of twenty-four residents resulting in a significant weight loss. Findings include: 1. R4 was admitted to the facility on 10/03/08 with a baseline weight of 154.8 pounds. R4's weight remained fairly stable until March 2009 with a weight of 148.1 pounds. A review of nursing notes from 03/03/09 through 03/21/09 reflected eight days of chronic diarrhea and Medication Administration Records (MAR) reflected numerous accounts of treatment with Imodium (anti-diarrheal medication) during this time frame. On 03/17/09 according to nursing notes, a note was left for the Primary Care Physician to evaluate (two weeks after the onset of diarrhea) and new orders were obtained for a stool sample to be check for Clostridium Difficile (C. Diff) Toxins. On 03/19/09, a stool sample was obtained and proved positive for C. Diff. Toxins (a transmittable bacteria in the stool that causes diarrhea) on 03/21/09. R4 was placed in isolation on 03/21/08 and Flagyl 500 mg. (antibiotic) was started for ten days of treatment. R4's weight on or before April 10, 2009 was 134.6 resulting in a significant 13.5 weight loss for the month of March 2009 or 9%. During the period of chronic diarrhea from 03/03/09 through 03/21/09, neither a care plan was implemented nor were interventions put in place to prevent or monitor for weight loss related to the chronic diarrhea. Subsequent to treatment with Flagyl, R4's weight began to stabilize and the	F 325	notifying physicians of a change in condition have been reviewed and updated to insure that the needs of the resident are being met timely and the physician is being given an accurate reflection of the changes in condition the resident is experiencing. Nursing staff have been in-serviced on the new policy and guidelines for physician notification. Nursing management will review the 24 hour report daily to insure that licensed staff are notifying the physician of changes in condition and the physician is responding back with orders within time frames established in the policy guidelines. All changes in condition will be reviewed in morning meeting to insure there has been appropriate follow through on all changes. b) • A weekly audit x 4 weeks will be completed on 5 residents on each unit with a change in condition for 4 weeks and then monthly for 3 months. Audits will be	6/18/09

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F 325	Continued From page 28 most current 3rd weekly weight had increased to 139.7 lbs. The facility failed to recognize R4's risk for weight loss and failed to provide services in a timely manner to address the diarrhea, resulting in a significant weight loss of 9% over a one month period.	F 325	reviewed during the monthly QA/QI meeting and modified and or continued as needed.	
F 327 SS=G	483.25(j) HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined that the facility failed to ensure that one (R24) out of 24 sampled residents was provided with sufficient fluid intake to maintain proper hydration and health. The facility failed to identify the increased risk of dehydration for R24 when the resident had only 300 cc (cubic centimeters) of fluids during a four day period of time. The facility failed to respond in a timely manner to the resident's inadequate fluid intake resulting in the resident being admitted to the hospital where she was found to have abnormal laboratory values and dehydration. Findings include: R24 was admitted to the facility on 11/28/08 with diagnosis which included advanced dementia, multiple strokes, atrial fibrillation, hypertension and hypothyroidism. The initial Minimum Data Set (MDS) assessment dated 12/3/08 indicated that the resident was	F 327	F- 327 A) • Resident identified no longer resides in this facility. B) • Residents with an un-identified risk of dehydration have the potential to be affected by this practice. C) • A full audit was done of all residents to insure that their potential for dehydration had been identified and interventions have been put in place to address this. Policy for Hydration was reviewed and updated. New forms were added to assist the facility with data collection to better assess the potential for dehydration. An in-service was completed to teach the staff the new policy and use of monitoring forms. All members of the interdisciplinary team were included in training to insure all disciplines were involved in this process. Residents at risk for dehydration will be	

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F 327	Continued From page 29 moderately impaired for decision making. In addition, the resident required supervision and set up for eating. A Medicare MDS assessment dated 12/11/08 indicated a decline in eating to totally dependent with one person physical assist. Admission medications included Namenda 10 mg BID (twice a day), Seroquel 25 mg BID (can cause sedation), Norvasc 5 mg QD (daily), Synthroid 0.05 mg QD, and Prozac 20 mg QD. On 11/29/08 the nurse practitioner (E26) added Xanax 0.25 mg every 8 hours as needed for increased anxiety and agitation (can cause sedation). On 12/7/08 the psychiatrist (E31) increased the Seroquel to 25 mg TID (three times a day) and the Xanax to 0.25 mg TID hold for sedation. The resident was exhibiting behaviors of agitation including hitting, biting and kicking staff. The admission blood work at the facility dated 11/29/08 indicated the resident's blood urea nitrogen (BUN) level was elevated at 26.0 (normal range 8-23 mg/dL) and that the creatinine level was normal at 1.30 (normal range 0.6-1.5 mg/dL). In addition, the sodium level was within normal limits at 139 (normal range 137-145 mMOL/L). BUN, creatinine, and sodium levels are indicators of fluid imbalance and renal function. Repeat blood work on 11/30/08 indicated a BUN elevated at 32, creatinine elevated at 1.6 and a normal sodium at 138. There were no new physician orders as a result of this bloodwork. The facility's policy Hydration Assessment and Monitoring documented that a resident who had been identified as being at risk for dehydration should be placed on Intake and Output (I&O) monitoring and documentation every shift for at	F 327	identified through the MDS process, intake monitoring, and by the Dietician and Physician. Physicians will be notified within 24 hours of residents who have had a significant decrease in their intake in a 24 hour period and/or show symptoms of dehydration. Fluid intake sheets will be brought to the weekly risk meeting to insure all residents with decreased intake and those identified as being at risk for dehydration will be reviewed by the inter-disciplinary team to insure interventions are in place and appropriate. D) • An audit will be completed on 10 random residents on each unit every day for 2 weeks. The audit will then continue weekly for 3 months and then monthly thereafter. Results of this audit will be brought through the QI/QA process and will be reassessed for continuing auditing need or changes.	6/18/09

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F 327	Continued From page 30 least three days or until improved. The policy indicated that this should be placed on the care plan. Additionally, the policy documented that at the end of each 24 hour period the resident's fluid intake should be compared to the minimal fluid requirement of 1500 cc/day. It further revealed that a nurse may initiate I&O at any time based on professional assessment and judgement. On 11/28/08 staff initiated a three day intake and output record that according to Standing Physicians Orders signed 11/29/08 which was done on all new admissions. Facility staff failed to make entries each shift and failed to total what they did enter. There was no evidence that this document was evaluated by staff to identify a hydration risk. A hydration risk assessment completed on 11/28/08 by nursing staff scored 10 which indicated the resident was not a high risk for dehydration. However, the staff completing the form did not have sufficient information to complete all areas of assessment. Had the first three days of resident intake been evaluated the resident would have coded high risk for hydration. The review of the initial nutritional assessment by the registered dietitian (E29) dated 12/1/08 documented that R24 was at nutritional risk secondary to leaving greater than 25% of meals uneaten and her estimated fluid requirement was 1650 cc. The speech therapist (E30) assessed the resident on 12/5/08 and indicated the resident was at risk for inadequate nutrition and hydration. The facility had an interim plan of care that identified hydration as a problem area on 11/30/08 with the approaches to provide fluid as ordered and monitor labs. Hydration needs were	F 327		

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F 327	Continued From page 31 not included in the full care plan developed by the interdisciplinary team. The facility did document a hydration risk stamp nurse's note on 12/4, 12/10 and 12/19/08 that failed to identify the lack of sufficient fluid intake by R24. The stamp on 12/19 did identify amber colored urine. On 12/9/08 the resident was started on an antibiotic for treatment of a urinary tract infection. The facility's General Hydration Policy and Procedure documented "8. Report refusals of fluids or problems ingesting fluids to the charge nurse, so she can report it to the physician". The document "Fluids" record kept by direct care staff to document the cc's of fluid consumed at meals, snacks and extra was reviewed. This form collects data but has no area to total the daily fluids to evaluate the residents intake. Calculations by the surveyor indicated that for the 23 full days that R24 was at the facility she consumed an average of 446 cc per day. Ranging from 960 cc to 0 cc each day. The last four full days (12/18 thru 12/21/08) the resident was at the facility a total of 300 cc's were consumed. The resident took no medications by mouth 12/20, 12/21, and 12/22/08 due to sleeping and lethargy. The resident's blood pressure (BP) also decreased from an admission BP of 140/62 to the last three days of admission 12/20 -118/74, 12/21 - 110/64, 12/22 -90/48 and 88/50 which can also be indicative of hypotension related to volume depletion. On 12/19/08 the nurse practitioner (E26) ordered an extra 240 cc of fluid each shift for hydration	F 327		

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F 327	Continued From page 32 and to document the amount consumed. Staff were able to get R24 to consume 55 cc on 12/19/08 and no additional fluids after that date. There was not evidence that this lack of consumption was reported to E26. Interviews on 4/23/09 with the DON (E19) who reviewed the 24 hour report and physician communication book, the nurse (E27) who cared for the resident daily and E26 who visited on 12/19/08, revealed that there was no contact with the physician concerning the lack of intake and increased lethargy until 12/22/08 at 1:30 PM when R24 was sent out 911 to the emergency room. These findings were confirmed on 4/23 and 4/28/09 with the Administrator (E18) and DON (E19). R24 was admitted to the hospital with diagnoses of dehydration with acute hypernatremia, acute renal failure and metabolic acidosis, mental status changes that appear to be secondary to metabolic acidosis, rule out urinary tract infection and rule out sepsis. The resident had an elevated BUN at 172, elevated creatinine of 7.1 and an elevated sodium at 175.	F 327		
F 328 SS=B	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care;	F 328	F- 328 A) • Residents identified had their concentrators cleaned and new filters put in place. B) • Residents on oxygen have the potential to be affected by this practice. All concentrators were checked to insure clean filters were in place.	

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F 328	Continued From page 33 Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined that the facility failed to ensure that oxygen concentrators had filters in them. Findings include: During the environmental and initial tour on 4/15/09, filters were missing in oxygen concentrators in resident rooms 121A and 319. Food service director (E21) interview confirmed the findings. A procedure on the cleaning of the concentrators was reviewed and revealed the filters needed to be washed twice/week.	F 328	C) Policy for cleaning and checking concentrators was reviewed and shared with staff. Oxygen tubing and humidifiers will be dated and changed weekly and as needed. Filters will be cleaned at this time and replaced if needed. The 11-7 shift will be responsible for completing this task. An in-service was completed for this responsibility. D) Monitoring will be completed during Mon-Fri Ambassador rounds with documented results brought to the Admin. Results will be reviewed in morning meeting for compliance. Any further concerns with compliance will be brought through the QA/QI process as needed.	6/18/09
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	F 329	F-329 A) Resident identified no longer resides in our facility. B) Residents receiving a medication regime of psychotropic drugs have the potential to be affected by this practice. A meeting was held with the psychiatrist to	

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F 329	Continued From page 34 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of hospital records it was determined that the facility failed to ensure that one (R24) out of 24 sampled residents was free from unnecessary drugs. R24 had experienced a significant change in physical and mental status including a decline in oral intake and lethargy. The facility failed to ensure adequate monitoring of the resident's medication regime failed to identify and failed to minimize clinically significant adverse consequence, which resulted in the resident being hospitalized due to dehydration. Findings include: Cross refer F327 R24 was admitted on Seroquel 25 mg BID (anti-psychotic) which was the same dose the resident was on at home. On 11/29/08 the NP (E26) added Xanax (anti-anxiety) 0.25 mg every 8 hours as needed (PRN) for increased anxiety and agitation. Nurses' notes indicate the medication was requested because the resident was hitting staff and throwing things. Nurses' notes reveal the resident would hit, kick and bite staff when attempting to administer care.	F 329	do a Medication Regime Review of all residents on psychotropic meds to address the possibility of titration and discontinuation of these medications. These residents were also reviewed for the appropriateness of non pharmacologic interventions to address these behaviors and care plans were updated to reflect any changes. a) New residents and residents exhibiting new behaviors will be reviewed by the interdisciplinary team for the cause of these behaviors and how they can be addressed safely without psychotropic medications when possible. Care plans will be implemented to include both pharmacologic and non pharmacologic interventions. Residents will also be assessed for pain and non-verbal pain indicators as a cause of the behavior. b) A monthly meeting will be held with the interdisciplinary team to review the continued need of psychotropic meds.	

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F 329	Continued From page 35 Review of the November 2008 MAR revealed that the PRN Xanax was used once on 11/29 and once 11/30/09. Review of December 2008 MAR revealed the Xanax was used 12/1 x1, 12/2 x1, 12/3 x2, 12/5 x2, 12/6 x1, 12/7 x1, 12/8 x1 and 12/9 x1 for increased agitation and combative behaviors. The medication was discontinued on 12/7/08 although staff continued to administer through 12/9/08. On 12/7/08 the Xanax PRN order was changed to Xanax 0.25 mg TID hold for sedation despite the fact the resident was only receiving this medication 1 to 2 times a day on an as needed basis. The psychiatrist (E31) also increased the Seroquel 25 mg to TID. Both of these medications can cause sedation. The resident's MDS assessments showed a decrease in the resident's ability to preform activities of daily living after the the medications were increased. The facility did not develop a care plan to monitor for R24's behaviors until 12/3/08 after the Xanax had been initiated. There was no documentation of what non-pharmological approaches had been attempted prior to the use of medication. Review of the side effect monitoring tool used by the facility revealed that staff only monitored for side effects 23 out of 57 opportunities or 40% of the time. Review of R24's behavior monitoring form revealed that there was little evidence that the medications were significantly decreasing the behaviors of hitting, biting and kicking. A pharmacy review conducted on 12/11/08 did not question the increase in these sedating medications.	F 329	Medication Regime Reviews by the Pharmacist will also be used for possible dose reduction. Use of psychotropic meds identified in the QI's will be reviewed monthly by the DON or member of the nurse management team and the Director of Social Services through the QA/QI process.	6/18/09

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F 329	Continued From page 36 An interview on 4/28/09 with E26 (Nurse Practitioner) revealed that the sedation effects of the increased medication could have contributed to the lethargy and decreased oral intake. Between 12/18 and 12/22/08 the resident became more sedated, stopped eating, was unable to take medications and consumed only 300 cc of fluid. The resident was admitted to the hospital on 12/22/08 with dehydration.	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION The facility must develop policies and procedures that ensure that – (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical	F 334	F-334 A) Resident R17 was given the Pneumococcal and Influenza vaccine. Resident R12 was given the Pneumococcal vaccine during the survey process. Residents R1, R6, R10, and R21 and/or their legal representatives were given instructional material on the benefits and side effects of receiving the Influenza immunization. R17/R12 had no had previously. B) All residents have the potential to be effected by this practice. C) New educational material was provided to all residents and their responsible parties on the benefits and side effects of both the Pneumococcal and Influenza vaccines. Immunization records were reviewed to insure all residents were offered the Pneumococcal vaccine. Staff was in-serviced on the Immunization	

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F 334	Continued From page 37 contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced	F 334	policy and the need to provide educational materials with the consent forms. D) • Compliance will be monitored with new residents through chart review at morning meeting. Immunization logs will be updated and residents with prior refusals for the Pneumococcal vaccine will be approached quarterly to see if they continue to refuse this vaccine. Residents with prior refusals to the Influenza vaccine will be approached annually to see if they continue to refuse this. Logs will be monitored quarterly for compliance and brought through the QA/QI process as needed. Instructional Material will be presented at time of admission.	6/18/09

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F 334	Continued From page 38 by: Based on reviews of clinical records, facility documentation, and staff interview, it was determined that the facility delayed administration of influenza and pneumococcal vaccinations for one resident (R17) and failed to re-offer pneumococcal vaccination to one resident (R12) out of 24 sampled residents. In addition, the facility failed to ensure that the residents or legal representatives were educated with the benefits and the potential side effects of receiving an influenza immunization for four (R1, R6, R10, and R21) out of 24 sampled residents. Findings include: 1. R17 was admitted to the facility on 12/31/08. At the time of admission, R17 was presented with a influenza vaccination consent form and gave consent to have the vaccine administered by the facility. The facility delayed in administering the vaccine. The vaccine was not given until 02/24/09. 2. R17 was admitted to the facility on 12/31/08. At the time of admission, R17 was presented with a pneumococcal vaccination consent form and gave consent to have the vaccine administered by the facility. The facility delayed in administering the vaccine. The vaccine was not given until 02/24/09. 3. R12 was admitted to the facility on 04/29/04. At the time of admission, R12 was presented with a pneumococcal vaccination consent form and refused the vaccination. Subsequently, on 11/11/05 she decline the vaccination. R12 was not re-offered the vaccination again until an inquiry was made by the surveyor on 04/17/09, at that time she accepted and was administered the	F 334		

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F 334	Continued From page 39 pneumococcal vaccination on 04/17/09. 4. Review of clinical records for R1, R6, R10, and R21 revealed that the influenza immunization for the 2008-2009 flu season was offered to these four residents and it was refused. Review of the facility's Influenza Immunization policy reads that the Influenza immunization will be offered to all residents each year from October 1 through March 31 each year. In addition, the facility will provide the patient and/or the responsible party education on the benefits and potential side effects of the immunization. Review of resident clinical records lacked evidence that the resident or legal representative received education on the benefits and potential side effects of the immunization. An interview with the unit manager, E16 on 4/23/09 at 11:45 AM revealed that facility reviews the benefits and potential side effects of the immunization upon admission when initial consent is obtained, however, this is not done on a yearly basis with the residents. E16 confirmed that there was no evidence that these residents were educated on the benefits and potential side effects of the influenza immunization.	F 334		
F 371 SS=F	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 371	Continued From page 40 This REQUIREMENT is not met as evidenced by: Based on observations and interviews in the dietary area on 04/15/09, and 4/20/09, it was determined that the facility failed to store, prepare, distribute, and serve food under sanitary conditions. Findings include: 1. On 4/15/09 at 8:45 AM, the 2-compartment vegetable sink in the kitchen was observed with no air gap in the drain line. The absence of an air gap between the drain line and the floor drain has the potential for contaminating the sink via backflow from the floor drain. An interview with the food service director (E21) confirmed this finding. Additionally, on 4/15/09 at 10:15 AM, the Aspen pantry ice machine drain line did not exhibit an air gap. On 4/17/09 at 10:50 AM, the Sierra pantry ice machine drain line did not exhibit an air gap. The drain pipe from the ice machine was indirectly piped into the facility sewer line not exhibiting a gap. Upon touch, the drain line pipe collapsed and was observed in disrepair. 2. Evidence of health information reporting for three dietary employees (E11, E12 and E14) of three dietary staff was missing. E21 and human resource staff (E22) confirmed that none of these employees had a form completed. Forms were signed by staff on 4/19/09. 3. On 4/15/09 at 9:00 AM, the following kitchen equipment was observed with food debris, grease deposits, black tar, and/or encrusted with food deposits:	F 371	A) No residents were identified. All cited concerns will be corrected by 6/18/09. B) All residents have the potential to be affected by the deficient practice. C) A cleaning checklist was developed and has been be implemented. 1. Air gap on line was corrected 4/17/09.Aspen and Sierra pantries were corrected 5/20/09. 2. All employee health questionnaires were completed 4/19/09. 3. Staff in-service and items were corrected 5/19/09. 4. Ice machine was cleaned on 4/17/09. 5. The gauges were inspected by contractor and will be replaced by 5/31/09. 6. Ceiling tiles were replaced 5/19/09. D) An audit of the cleaning checklist will be monitored by FSD or designee weekly x's 4	

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F 371	Continued From page 41 a.. Four (4) out of fourteen (14) coffee mugs on trays stored on the clean ready-to-use rack of the kitchen were observed with heavy encrusted apple sauce debris on the food contact surfaces. b. Two of six burners of the Vulcan stove were observed encrusted with grease, black debris, and food deposits. The oven door inside surfaces and bottom of the oven in the kitchen were observed with yellow encrusted deposits. c. Five frying pans stored on the ready-to-use rack were observed with grease deposit in the food contact surfaces in the clean storage area in the kitchen. d. The lids of the sugar bin, beef base, and the chicken base bins were observed dirty. e. The sugar, chicken base, and beef base scoops were stored on top of dirty bins. 4. Black build up on the inside surface of the ice machine plastic in the kitchen was observed. 5. The dishwasher wash temperature gauge, and the booster heater dishwasher gauges were not functioning. 6. Three ceiling tiles were stained in the kitchen above the dishwasher.	F 371	weeks. The results will be presented to QA for the next two consecutive quarters. F372 A) No residents were identified. B) All residents have the potential be affected by this deficient practice. C) Dietary staff FSD/FPM and cooks will conduct a walk thru of dumpster area 5 x's per day to assure compliance. A daily checklist will be maintained. D) The results of checklist will be monitored 1x per week x's 4 weeks for compliance and the results will be presented to the QA committee for the next two consecutive quarters.	6/18/09
F 372 SS=C	483.35(i)(3) SANITARY CONDITIONS - GARBAGE DISPOSAL The facility must dispose of garbage and refuse properly.	F 372		6/18/09

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F 372	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on observations of the garbage dumpster area, Sierra unit pantry area, and interviews, it was determined that the facility failed to dispose of garbage and refuse properly. Findings include: On 4/15/09 at 9:35 AM, two of four dumpster doors and/or lids were observed open while filled with trash. On 4/15/09 at 2:36 PM, two dumpster doors were observed open. On 4/17/09 at 7:34 AM, one dumpster door was observed open. On 4/20/09 at 8:30 AM, one dumpster door was observed open. This provides harborage for pests and creates a foul odor. Additionally, observations on 4/15/09 and 4/21/09 of the Sierra unit pantry area revealed an uncovered trash container. Food service director (E21) confirmed these findings.	F 372		
F 431 SS=B	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431	F431 A) No residents were identified. B) Residents receiving medication stored in the medication refrigerators have the potential to be effected by this deficient practice. C) All refrigerators were checked by the maintenance staff to insure they were working properly. Licensed staff was in-serviced on the importance of monitoring and documenting temperatures of the refrigerators. D) Monitoring of compliance will be accomplished by weekly checks of the refrigerator logs by nursing management. Results of this monitoring will be brought through the QA/QI process for review as needed. 6/18/09	

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F 431	Continued From page 43 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations on 4/21/09 and staff interview, it was determined that the facility failed to ensure that all drugs and biologicals were stored under appropriate environmental controls. Findings include: Review of the two nursing station (Aspen and Sierra) medication refrigerator temperature logs revealed the facility failed to consistently monitor and record the medication refrigerator temperatures to ensure that all drugs and biologicals were under appropriate environmental controls. Interview with the staff development staff (E25) confirmed this finding. 1. Sierra Medication Refrigerator: Review of logs from January 2009 through April 19, 2009 revealed undocumented temperatures	F 431		

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F 431	Continued From page 44 for 39 of 109 days. 2. Aspen Medication Refrigerator: Review of temperature logs from January 09 through April 19, 2009 revealed undocumented or blank temperature readings for 19 of 109 days.	F 431		
F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on facility staff documentation, staff interview, and review of the facility's tuberculosis screening policy and procedures, it was determined that the facility failed to maintain an infection control program that ensured staff received a two step tuberculin test when appropriate. The facility failed to conduct complete tuberculosis screenings on 13 out of 17 sampled staff (E1, and E4 through E15). The facility did not follow a PPD (purified protein derivative) procedure required by State guidelines. Findings include: 1. Employees E1, and E4 through E15 were hired between 7/21/08 and 3/18/09. There was no documentation that the second step of a two-step	F 441	F441 A) Employees identified were all reviewed and the 2 step ppd was administered where negative. B) Residents would have the potential to be affected by this practice if an employee was not screened for Tuberculosis as required by State and Federal regulations. No employee was found with active TB. C) Employee screening policy has been reviewed to insure it includes the following requirements: All new employees will be required to have a 2 step PPD when negative. An employee with a positive conversion or previous positive conversion will be given a chest x-ray if no previous chest x-rays have been done. They will also complete a questionnaire to insure they do not have active	

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F 441	Continued From page 45 tuberculin (PPD) test was conducted upon hire of the staff. There was also no record on file that the staff had a prior tuberculin (PPD) test prior to work at this facility. An interview with staff development nurse E25, in charge of the tuberculin tests (PPD), Purified Protein Derivative, program, on 4/17/09 at 9:15 AM confirmed the findings. According to the facility's infection control policy and procedure on immunizations and Tuberculosis, the procedure does not address when employees receive a tuberculin test and how many tests they get. The procedures states that "if positive PPD develops redness and swelling at site in 12-24 hours, then positive PPD is sent to the chest clinic and any further follow up as needed". A two-step Mantoux TB skin test was not addressed in the procedure as required by State regulations.	F 441	symptoms of TB and will complete this questionnaire annually. All new employees will be given a TB questionnaire on hire to insure active cases of TB are not brought into the facility prior to PPD testing. 5) • Monitoring of compliance will be done by the staff developer and brought to the monthly QA/QI meeting for review.	6/18/09
F 445 SS=E	483.65(c) INFECTION CONTROL - LINENS Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation during the environmental tour and interviews with the staff, it was determined that the facility failed to handle and store linens to prevent the spread of infection. Findings include: 1. On 4/15/09 at 2:20 PM, the door to the laundry room between the clean linen area and the soiled linen area was observed open. Staff interview with the housekeeping director (E23) confirmed the doors between clean and dirty should be	F 445	F445 A) No residents were identified at this time. B) All residents have the potential to be affected by this deficient practice. C) Storage/handling of linens policy/procedure will be review with housekeeping and Maintenance staff. 1) Door closure will be installed on doors by June 18, 2009. Infection control procedure will be revised by 6/18/09 to reflect need for door being closed.	

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PINNACLE REHABILATATION & HEALTH CENTER	3034 SOUTH DUPONT HIGHWAY SMYRNA, DE 19977

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F 445	Continued From page 46 closed. In-servicing was later provided. On 4/17/09 at 7:50 AM, the same door between clean and dirty soiled linen of the laundry room was observed cracked open. The clean linen room was not kept under positive pressure and the soiled area of the laundry was not kept under negative pressure. The doors being opened allowed soiled air to enter the clean area of the laundry room. The infection control procedure titled Laundry/Linen did not address the laundry doors being closed or ventilated. Interview with E23 confirmed this finding. 2. Throughout the survey, full soiled linen carts were observed stored on the hallways of all the facility floor units which had stagnant flow or no air movement. Smells were detected at times coming from these carts. The facility incorrectly stored soiled linen in the hallways. 3. The hot water wash temperature in the washer of the laundry room was observed at 90 degrees Fahrenheit versus the required temperature of 160 degrees Fahrenheit minimum. The hot water temperature of the hand sink in this area was detected at 100 degrees Fahrenheit. Observations of the hot water tanks temperature gauges revealed the hot water supply temperature to the washers at 120 degrees Fahrenheit. Interviews with E23 on 4/17/09 revealed he was not aware of the hot water wash temperatures and was not monitoring. E23 also revealed he was unsure if the contractor was doing any monitoring of temperatures.	F 445	2) Staff to be in serviced on ensuring that soiled items being taken directly to laundry or trash. 3) Contractor to be in q 3month to monitor temperature in washer to ensure compliance. D) Housekeeping Director will notify Administrator or designee if issue continues and it will be brought to QA/QI for further review. Mixing valve was installed on hot water heater to ensure more accurate temperatures.	6/18/09

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F 445	Continued From page 47 A call to the chemical contractor revealed they did not measure temperatures of the water. E23 contacted the chemical contractor for the washers and revealed the contractor was trying to determine if chemicals used by the facility removed potential infectious diseases in the washers without the hot temperatures required.	F 445		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations made during the environmental tour, and staff interviews, it was determined that the facility failed to have an emergency call system on resident room 204A, the Aspen and Sierra tub common shower rooms/central baths for residents to call staff for help. Findings include: 1. Observations on 4/15/09 and 4/21/09 of the toilet area of the Aspen and Sierra central baths revealed that the call bell system was missing. The Aspen central bath did not have an emergency call light system on one whirlpool area and one shower stall although it had one by a second whirlpool. The Sierra central bath did not have an emergency call system by the two shower stalls although the two whirlpool areas did have one. Interview with the facility maintenance director (E24) revealed that the call bell systems were not installed when the facility was built.	F 463	F463 A) The call bell for 204A was operational on 4/17/09. The tub rooms on Aspen and Sierra have call bells in the bathing areas. B) No residents were affected by this deficient practice C) Any resident that is bathed in the tub room will have a staff member present at all times. 1. All tub rooms have functioning call bells. 2. Call bells will be checked and repaired if need be by June 18, 2009. 3. Call bell functioning 4/17/09. 4. Covers were ordered and replaced 5/22/09. D) A random audit of call bells will be conducted 1 x per week x's 4 weeks and the results will be presented in QA for the next two consecutive quarters.	6/18/09

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F 463	Continued From page 48 2. Observations on 4/15/09 at 10:10 AM of the emergency call light system of resident room 204A revealed the light outside the door was not working and was malfunctioning. After repeated attempts to correct the panel of the light system on the room wall, E21 (food service director) did make the light work outside the door for resident room 204A. Resident room 204B emergency call light system did not have sound or a light signal outside the door after repeated attempts to fix the panel area. 3. On 4/15/09 at 2:10 PM, the emergency call light on the outside door of the Seaside (Bath 1) central bath was not working. 4. On 4/15/09 at 1:30 PM, the cover of the emergency call light outside the door was missing for resident rooms 101, 102, and 300. Interview with maintenance staff (E24) and housekeeping staff (E23) revealed the covers were damaged during the construction and they were planning to order more covers to replace them.	F 463		
F 465 SS=B	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations during the environmental tour, it was determined that the facility failed to provide a sanitary and safe environment. Findings include:	F 465	F465 A) Employee E35 was in-serviced on the appropriate handling of trash. All personal items in the Sierra tub room were removed. Unlabeled personal items in rooms 326, 333, and 338 were cleaned and labeled appropriately. Items found on the floor of the Seaside shower room and in the shower room were removed.	

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F 465	Continued From page 49 1. On 4/17/09 at 2:55 PM, a housekeeping staff (E35) was observed throwing bags of trash from the Aspen soiled utility work area #1 in a large barrel in the hallway of the unit. Residents and certified nursing staff were standing near by. This has the potential for spreading infections due to the agitation of microbial contamination and spreading in the air. 2. Observations of the residents' Sierra tub room central bath on 4/15/09 at 11:05 AM revealed a storage cabinet with unlabelled personal resident items including an Avon powder container, Vaseline container, 16.5 oz sanitizer bottle, hair spray, toothbrush and toothpaste, and a bar of soap. An opened unlabelled Tena shampoo bottle was observed in one shower stall. 3. Observations of the residents' Aspen tub room central bath on 4/17/09 at 11:20 AM, revealed unlabelled personal resident items throughout the rooms including three opened Tena used up containers, and one pair of shoes on top of a cart. Unlabelled personal items were observed on the hand sink of resident room 326, 333, 338 such as hair brush, Aloe Vera cream, spray powder, perineal wash spray bottle, and Tena shampoo bottle. On 4/15/09 at 2:10 PM and 4/20/09 at 9:15 AM, a one gallon container of body shampoo was observed on the floor of the Seaside resident central bath shower stall; one Tena shampoo bottle was observed resting in one shower stall, and two pink caddys full of personal items belonging to residents were observed unlabelled and accessible to residents in the same shower room. On 4/20/09 at 9:15 AM, a one gallon container of body shampoo was observed on the	F 465	Personal items found in the shower room were removed and labeled and put in the appropriate resident rooms. B) Bedpans found in rooms 300, 310, and 333 were removed and discarded. New bedpans with proper labels were placed in the rooms in plastic bags. Dustpan and yellow bucket on Seaside were cleaned. C). Housekeeping and C.N.A.'s were in-serviced in infection control and the importance of labeling and securing personal items. The Dept Managers will be re-in-serviced on how to do Ambassador Rounds. Ambassador Rounds will be made daily Monday-Friday to insure that infection control concerns are being addressed. Documented rounds will be brought to morning meeting to insure the appropriate Dept. manager is following up on all concerns. D). Results of the Ambassador rounds will be brought to the Administrator for review.	6/18/09

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F 465	Continued From page 50 floor of the Seaside resident central bath shower stall and one Tena shampoo bottle was observed in one shower stall. 4. On 4/15/09 at 12:01 PM, three pink bedpans were observed on the tub of resident room 310 unlabelled and uncovered. On 4/16/09 at 8:20 AM, bedpans were observed on the floors of resident rooms 300 and 333. 5. On 4/15/09, soap was missing from the Aspen resident central bath hand sink. 6. On 4/17/09 at 11:00 AM, the dust pan and the yellow bucket of the cleaning cart outside the Seaside hallway (outside room 328) was observed with encrusted dirt.	F 465	Any concerns will be brought through the QA/QI process for review. F467	
F 467 SS=B	483.70(h)(2) OTHER ENVIRONMENTAL CONDITIONS - VENTILATION The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation of the Aspen janitor room and soiled utility room, resident bathrooms and the hallways of each floor, and staff interviews, it was determined that the facility failed to maintain adequate ventilation as reflected by missing, malfunctioning, and taped exhaust vents. Findings include: 1. On 4/15/09, the bathroom exhaust vents in resident room 202, 204/206, and 207 were found to have no negative air flow exiting the room through the ceiling exhaust unit. The exhaust	F 467	A) rooms 202, 204, 206, 207 were corrected on 5/11/09. Rooms 310, 318, 326 will be corrected by 6/15/09. 2). Corrected 5/11/09 3.) Corrected 5/11/09. B) All residents have the potential to be affected by the deficient practice. C) A service contract was signed by NHA for maintenance of vents on 5/20/09. D) Air flow will be monitor 1 x per week x's 4 weeks and the audit will be presented to QA for the next two consecutive quarters.	6/18/09

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F 467	Continued From page 51 vents in resident rooms 310, 318, 326 had the vents covered with grey tape. Interview with the facility's maintenance director (E24) confirmed that the rooms had no motor exhausting the air in the resident rooms. 2. On 4/15/09, the janitor closet #2 in the Aspen unit was found to have no negative air flow exiting the room through the ceiling exhaust vent. Uncovered trash bags were in the room. Interview with the housekeeping director (E23) confirmed this finding. 3. The vent in Aspen soiled utility room where uncovered trash and biohazard waste containers were stored, was not exhausting or working. Interview with E24 revealed that the vents only work when the air conditioner was on.	F 467		
F 500 SS=C	483.75(h) USE OF OUTSIDE RESOURCES If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h)(2) of this section. Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services.	F 500	F500 A) No residents were identified. B) The facility does have a qualified dentist who provides services to the residents and the facility so no residents are affected by this deficient practice. C) A call was placed to the physician who provides services to attempt to set up contract. D) A contract with a dentist will be signed by June 18, 2009.	6/18/09

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F 500	Continued From page 52 This REQUIREMENT is not met as evidenced by: Based on review of the facility contract book documentation and staff interviews, it was determined that the facility failed to maintain a contract for dental services and the pharmacy service contract had expired. Findings include: Review of the contract book on 4/20/09 and 4/21/09 revealed there was no dental agreement although there was evidence that the facility is providing dental services. Additionally, the pharmacy contract expired on 1/15/08. Interview with the administrator (E18) confirmed this finding.	F 500		
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews it was determined that the facility failed to maintain complete and accurate medical records for four (SSR3, R12, R6, and R1) out of 24 residents in	F 514	F-514 A) Residents SSR3, R12, and R6 all had their POS's updated to reflect the current physician's orders. Resident R1 was evaluated by therapy for positioning and safety while eating. Resident had no adverse effects as a result of having no supervision while eating. No adverse effects were noted for any of these residents in relation to this practice. B) All residents have the potential to be affected by this deficient practice.	

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F 514	Continued From page 53 the sample. Findings include: 1. SSR3's physician order sheet (POS) for April 2009 was reviewed following a medication pass. Upon review, it was discovered that Docusate Sodium 100 mg. was discontinued on 03/19/09. The orders were carried over from March 2009 POS to the new April 2009 POS. Although discontinued on the Medication Administration Record (MAR) the order was not discontinued on the April POS. This finding was confirmed with the Unit Manager, E16 in Sierra. 2. R12's POS for April 2009 was reviewed and discovered to have two orders for Seroquel 100mg. The first order read Seroquel 100 mg. tablet by mouth every morning. The second order read Seroquel 100mg. 1 tablet by mouth twice daily, 9:00AM and 5PM. Although the first order was cancelled on the MAR, the order was not discontinued on the April POS. On 04/02/09, a medication regimen review by pharmacy made a notation of the double order however, the double order was not addressed until the surveyor brought it to the attention of the Unit Manager, E17 on 04/15/09. 3. Record of R6's physician's order in March 2009 revealed an order for R6 to be supervised for all meals. In addition, that R6 must be upright in most optimal position and remain in the upright position for 30 minutes after the meal. Review of the April 2009 monthly POS revealed that during the monthly recapitulation process, the facility failed to ensure that the order from March 2009 for the resident to have supervision for all meals was included in the April 2009 POS.	F 514	1) All nurses were in-serviced on how to properly follow through on a physician's order. Process for noting orders and chart checks were reviewed and updated to become more efficient with clear duties of responsibility. 2) An audit will be completed weekly x 4 weeks on 10 residents per unit to insure orders have been properly followed through to all areas of documentation. And chart checks are complete and thorough.	6/18/09

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F 514	Continued From page 54 Interview with unit manager, E16 on 4/22/09 at 1:30 PM confirmed the above findings. 4. On 4/23/09 at 8:45 AM, R1 was observed in bed eating her breakfast. The meal ticket from the Dietary Department noted R1 was on No Added Salt (NAS), No Concentrated Sweet (NCS), and low potassium diet. Review of the April 2009 monthly POS noted that R1 was on a NAS, NCS diet. An interview with E16 on 4/23/09 at 10 AM confirmed that R1 currently did not have an order for the low potassium diet and that the physician would be contacted for this issue. Subsequently, a physician's order was written on 4/23/09 for the low potassium diet.	F 514	F520 A) • No residents were identified in this tag. B) • There is a potential for all residents to be affected by this practice. C) • Medical Director was reminded of the State and Federal requirement that he attends the QA meetings at least quarterly and is not allowed to send representation in his place. Medical Director will be given the schedule for the QA/QI meeting for the next 6 months and then annually after that. The Administrator or designee will call the Medical Director several days prior to this meeting as a	
F 520 SS=F	483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the	F 520		

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F 520	Continued From page 55 requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility records it was determined that the facility failed to maintain a quality assessment and assurance committee that met quarterly consisting of the physician designated by the facility. Findings include: An interview with the administrator, E18 on 4/28/09 at 11 AM revealed that the physician designated by the facility was not present during the facility's quarterly quality assurance meetings on January 19, 2009 and July 17, 2008. No other physician designee was present.	F 520	reminder to when this is to take place. b) • Administrator or Director of Nursing will monitor compliance through the use of attendance sheets.	6/18/09

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

LTC Residents Protection
MAY 28 2009
Director's Office

STATE SURVEY REPORT

NAME OF FACILITY: Pinnacle Rehabilitation & Health Center

DATE SURVEY COMPLETED: April 28, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. **An unannounced annual survey and complaint visit was conducted at this facility from April 15, 2009 through April 28, 2009. The deficiencies contained in this report are based on observations, staff interviews, review of residents' clinical records, and review of other facility documentation as indicated. The facility census the first day of the survey was two-hundred five. The survey sample totaled thirty (30) residents which included a review of twenty-seven (27) active and three (3) closed clinical records. In addition, three (3) sub-sampled residents were included in the survey for observations.**	
3201	**Nursing Home Regulations for Skilled and Intermediate Care Nursing Facilities**	
3201.6.1	**General Services**	3201.6.1.1 Cross reference CMS-2567 – F157, F309, F312, F3232, F325, F327, F328, F329, F431, F465
3201.6.1.1	**The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet**	

Provider's Signature Kendal Geers, BS, NHA Title Administrator Date 5/26/09

NAME OF FACILITY: Pinnacle Rehabilitation & Health Center

DATE SURVEY COMPLETED: April 28, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	This requirement is not met as evidenced by: Cross-refer to CMS 2567-L survey date completed 4/28/09, F157, F309, F312, F323, Examples (2), (4), and (5), F325, F327, F328, F329, F431, F465 Example (7).	
3201.6.1.3	**The nursing facility shall have written agreements for promptly obtaining required laboratory, x-ray and other ancillary services.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 4/28/09, F500.	3201.6.1.3 Cross Reference CMS 2567 – F500
3201.6.2 **3201.6.2.3**	**Financial Services** **Upon the death of a resident, the facility shall convey within 30 days the resident's funds, and a final accounting of those funds to the individual or probate jurisdiction administering the resident's estate.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed	3201.6.2.3 Cross reference CMS 2567 F160

NAME OF FACILITY: Pinnacle Rehabilitation & Health Center

DATE SURVEY COMPLETED: April 28, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	4/28/09, F160.	
3201.6.5	**Nursing Administration**	
3201.6.5.7	**The assessment and care plan for each resident shall be reviewed/revised as needed when a significant change in physical or mental condition occurs, and at least quarterly. A complete comprehensive assessment shall be conducted and a comprehensive care plan shall be developed at least yearly from the date of the last full assessment.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 4/28/09, F279.	3201.6.5.7 Cross reference CMS 2567 F279
3201.6.9	**Housekeeping and Laundry Services**	
3201.6.9.1	**The facility shall employ sufficient housekeeping personnel and provide the necessary equipment to maintain a safe, clean, and orderly environment, free from offensive odors, for the interior and exterior of the facility.** **This requirement is not met as evidenced by:**	3201.6.9.1 Cross reference CMS 2567 F252, F253, F465

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	Cross-refer to CMS 2567-L survey date completed 4/28/09, F252, F253, F465, Examples 1 through 6.	
3201.6.12	**Communicable Diseases**	
3201.6.12.2	**Specific Requirements for Tuberculosis**	
3201.6.12.2.3	**All facilities shall have on file results of tuberculin tests performed on all newly admitted residents and newly hired employees, and annually thereafter on all employees. A tuberculin test as specified, done within the twelve months prior to employment, or a chest x-ray showing no evidence of active tuberculosis shall satisfy this requirement for asymptomatic individuals. If an individual was previously documented as a positive reactor or has a history of hypersensitivity to the PPD test, a negative chest x-ray shall meet this requirement.**	3201.6.12.2.3 Cross reference CMS 2567 F441
3201.6.12.2.6	**Persons who do not have a significant reaction to the initial tuberculin test shall be retested within 7-21 days to identify those who demonstrate delayed reactions. Initial tests done within one year of a previous test need not be repeated in 7-21 days.**	32.01.6.12.2.6 Cross reference CMS 2567 - F441

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	This requirement is not met as evidenced by: Cross-refer to CMS 2567-L survey date completed 4/28/09, F441.	
3201.6.12.3	**Immunizations**	
3201.6.12.3.3	**A resident who refuses to be vaccinated against influenza or pneumococcal pneumonia shall be informed by the facility of the health risks involved. The reason for the refusal(s) shall be documented in the resident's medical record annually.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 4/28/09, F334.	3201.6.12.3.3 Cross reference CMS 2567 F334.
3201.6.3	**Medical Services**	
3201.6.3.5	**After the initial physician visit, an advanced practice nurse or physician's assistant, affiliated with the physician, may alternate with the physician, making every other required visits.**	

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	This requirement is not met as evidenced by: R23 was originally admitted to the facility on 2/24/09. Record review revealed the admission history and physical was completed by a Nurse Practitioner. The initial progress note by the physician was completed on 3/4/09. An interview with E19 on 4/28/09 at 10:45 AM confirmed that the facility failed to ensure that the initial visit was completed by a physician	A) Resident R23 no longer resides in the facility. B) All residents in the facility have the potential to be affected by this deficient practice. C) Medical Director will be notified of regulations regarding Medical Services and the regulation for MD to make initial visit. Nursing staff to be in serviced by 6/18/09 in regards to these regulations as well. D) An audit will be conducted of all incoming residents for the next 30 days to assure compliance. This audit will be presented at the next two consecutive quality assurance meetings.
3201.7.3	**Facility Systems Requirements**	
3201.7.3.1	**Water Supply and Sewage Disposal**	
3201.7.3.1.3	**Hot water accessible to residents shall not exceed 110° F.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 4/28/09, F323, Example (1).	3201.7.3.1.3 Cross reference CMS 2567 - F323
3201.7.3.4	**The facility shall be equipped with a resident call system which meets the current standards of the Guidelines for Design and Construction of Health Care Facilities.**	3201.7.3.4 Cross reference CMS -2567 F463

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	This requirement is not met as evidenced by: Cross-refer to CMS 2567-L survey date completed 4/28/09, F463.	
3201.7.4	**Physical Environment Requirements**	
3201.7.4.3	**Bathrooms**	
3201.7.4.3.1	**Bathroom walls and floors shall be impervious to water. Bathrooms shall have at least one window or mechanical ventilation.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 4/28/09, F467, Example (1).	3201.7.4.3.1 Cross reference CMS – 2567 – F467
3201.7.5	**Kitchen and Food Storage Areas**	
3201.7.5.1	**Facilities shall comply with the Delaware Food Code.** **This requirement is not met as evidenced by:** Based on the dietary observation during the survey, it was determined that the facility failed to comply with sections: **2-201.11, 2-402.11, 3-304.12, 4-502.11, 4-601.11, 4-602.11, 5-202.11,**	3201.7.5.1 Cross Reference CMS 2567 - F371

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	5-501.15, and 6-501.11 of the State of Delaware Food Code. Findings include: **2-201.11 Responsibility of the Person in Charge to Require Reporting by Food Employees and Applicants.*** **The PERMIT HOLDER shall require FOOD EMPLOYEE applicants to whom a conditional offer of employment is made and FOOD EMPLOYEES to report to the PERSON IN CHARGE, information about their health and activities as they relate to diseases that are transmissible through FOOD. A FOOD EMPLOYEE or applicant shall report the information in a manner that allows the PERSON IN CHARGE to prevent the likelihood of foodborne disease transmission, including the date of onset of jaundice or of an illness specified under ¶ (C) of this section, if the FOOD EMPLOYEE or applicant:** **(A) Is diagnosed with an illness due to:** **(1) *Salmonella* Typhi,** **(2) *Shigella* spp.,** **(3) *Escherichia coli* O157:H7, or** **(4) Hepatitis A virus;**	2-201.11 Cross Reference CMS 2567 – F371

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	(D) Meets one or more of the following high-risk conditions: (1) Is suspected of causing, or being exposed to, a CONFIRMED DISEASE OUTBREAK caused by *S.* Typhi, *Shigella* spp., *E. coli* O157:H7, or hepatitis A virus including an outbreak at an event such as a family meal, church supper, or festival because the FOOD EMPLOYEE or applicant: (a) Prepared FOOD implicated in the outbreak, (b) Consumed FOOD implicated in the outbreak, or (c) Consumed FOOD at the event prepared by a PERSON who is infected or ill with the infectious agent that caused the outbreak or who is suspected of being a shedder of the infectious agent, (2) Lives in the same household as a PERSON who is diagnosed with a disease caused by *S.* Typhi, *Shigella* spp., *E. coli* O157:H7, or hepatitis A virus, or (3) Lives in the same household as a PERSON who attends or works in a setting where there is a confirmed disease outbreak caused by *S.* Typhi, *Shigella* spp., *E. coli* O157:H7, or hepatitis A virus. This requirement is not met as evidenced by:	

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	Cross-refer to CMS 2567-L survey date completed 4/28/09, F371, Example (2). **2-402.11 Effectiveness.** **(A) Except as provided in ¶ (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE ARTICLES.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 4/28/09, F371, Example (6). **3-304.12 In-Use Utensils, Between-Use Storage.** **During pauses in FOOD preparation or dispensing, FOOD preparation and dispensing UTENSILS shall be stored:** **(A) Except as specified under ¶ (B) of this section, in the FOOD with their handles above the top of the FOOD and the container;** **(B) In FOOD that is not POTENTIALLY HAZARDOUS with their handles**	2-402.11 Cross Reference CMS 2567 - F371 3-304.12 Cross reference CMS 2567 - F371

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	above the top of the FOOD within containers or EQUIPMENT that can be closed, such as bins of sugar, flour, or cinnamon; (C) On a clean portion of the FOOD preparation table or cooking EQUIPMENT only if the in-use UTENSIL and the FOOD-CONTACT surface of the FOOD preparation table or cooking EQUIPMENT are cleaned and SANITIZED at a frequency specified under §§ 4-602.11 and 4-702.11; (F) In a container of water if the water is maintained at a temperature of at least 60oC (140oF) and the container is cleaned at a frequency specified under Subparagraph 4-602.11(D)(7). This requirement is not met as evidenced by: Cross-refer to CMS 2567-L survey date completed 4/28/09, F371, Example (3e). 4-502.11 Good Repair and Calibration. (C) Ambient air temperature, water pressure, and water TEMPERATURE MEASURING DEVICES shall be maintained in good repair and be accurate within the intended range of use.	4-502.11 Cross reference CMS 2567 -F371

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	This requirement is not met as evidenced by: Cross-refer to CMS 2567-L survey date completed 4/28/09, F371, Example (5). **4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils.*** **(A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch.** **(B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations.** **(C) Non-FOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 4/28//09, F371 Example (3), a-d **4-602.11 Equipment Food-Contact Surfaces and Utensils.***	4-601.11 Cross Reference CMS 2567 – F371

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	(E) *Except when dry cleaning methods are used as specified under § 4-603.11*, surfaces of UTENSILS and EQUIPMENT contacting FOOD that is not POTENTIALLY HAZARDOUS shall be cleaned: (1) At any time when contamination may have occurred; (4) In EQUIPMENT such as ice bins and BEVERAGE dispensing nozzles and enclosed components of EQUIPMENT such as ice makers, cooking oil storage tanks and distribution lines, BEVERAGE and syrup dispensing lines or tubes, coffee bean grinders, and water vending EQUIPMENT: (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold. This requirement is not met as evidenced by: Cross-refer to CMS 2567-L survey date completed 4/28//09, F371 Example (4). **5-202.11 Approved System and Cleanable Fixtures.*** (A) A PLUMBING SYSTEM shall be designed,	4-602.11 Cross Reference CMS 2567 – F371 5-202.11 Cross Reference CMS 2567 – F 371

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	constructed, and installed 123 *and Installation* according to LAW. **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 4/28/09, F371, Example (1). **5-501.15 Outside Receptacles.** **(A) Receptacles and waste handling units for REFUSE, recyclables,** **and returnables used with materials containing FOOD residue and used outside the FOOD ESTABLISHMENT shall be designed and constructed to have tight-fitting lids, doors, or covers.** **(B) Receptacles and waste handling units for REFUSE and recyclables such as an on-site compactor shall be installed so that accumulation of debris and insect and rodent attraction and harborage are minimized.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 4/28/09, F372.	5-501.15 Cross Reference CMS 2567 – F372

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	6-501.11 Repairing. **The PHYSICAL FACILITIES shall be maintained in good repair.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 4/28//09, F371, Example (7).	6-501.11 Cross Reference CMS 2567 – F371
3201.7.6	**Sanitation and Laundry**	
3201.7.6.1	**The facility shall provide for the safe storage of cleaning materials, pesticides and other potentially toxic materials.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 4/28/09, F323, Example (3).	
3201.7.6.3	**For on-site laundry processing, the facility shall:**	3201.7.6.3 Cross reference CMS 2567 - F323
3201.7.6.3.1	**Provide a room under negative air pressure for receiving, sorting, and washing soiled linen. Washers must be supplied with hot water of 160° F.** **This requirement is not met as evidenced by:**	3201.7.6.3.1 Cross Reference CMS 2567 – F445

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	Cross-refer to CMS 2567-L survey date completed 4/28/09, F445, Examples (1), (3).	
3201.7.6.3.2	**Provide a room under positive air pressure for drying and folding clean linen, equipped with a hand washing sink.**	
	This requirement is not met as evidenced by	3201.7.6.3.2 Cross reference CMS 2567 – F445
	Cross-refer to CMS 2567-L survey date completed 4/28/09, F445, Example (1).	
3201.7.6.5	**The facility shall have a soiled utility room under negative pressure for storage of infectious waste and for disposal of body fluids. The room shall have a work counter, hand washing sink, and clinical sink or other bed pan cleaning device.**	3201.7.6.5 Cross Reference CMS 2567 – F467
	This requirement is not met as evidenced by:	
	Cross-refer to CMS 2567-L survey date completed 4/28/09, F467, Example (3).	
3201.8.0	**Emergency Preparedness**	
3201.8.2	**Regular fire drills shall be held at least quarterly on each shift. Written records shall**	

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	be kept of attendance at such drills. **This requirement is not met as evidenced by:** Based on review of the fire drill reports, and interviews, it was determined the facility failed to conduct or hold fire drills at least quarterly for the first, second, and third shift of 2008. First shift, third quarter fire drills were missed. No drills were conducted from 04/02/08 to 12/20/08. Second shift, second and third quarter fire drills were missed. No drills were conducted from 01/01/08 to 10/22/08. Third shift, second, third and fourth quarter fire drills were missed. No drills were conducted from 1/5/08 through 2/23/09. An interview with the M1 confirmed this finding.	3201.8.2 A) No residents were identified. B) All residents have the potential to be affected by this deficient practice. C) A contract was signed with a Provider to perform mandatory fire drills in accordance with state and Federal guidelines 9/08. D) An audit will be conducted of existing Fire Drills and will be presented to QA for the next two consecutive meetings.
16 Del. C., Chapter 11, Subchapter II, §1108	**Posting of inspection summary and other information and public meetings.** **(a) Each facility shall prominently and conspicuously post for display in a public**	

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	area of the facility that is readily available to residents, employees and visitors the following: **(c) The compliance history material must include all inspection reports produced for that facility during the preceding 3 year period. The information must be updated as each new inspection or other Department report is received by the facility.** **This requirement is not met as evidenced by:** Based on observation throughout the survey of the compliance history information, and staff interview, it was determined that the facility failed to keep all the inspection state reports available for examination during the preceding three year period, including the plan of correction. Findings include: Review of the facility compliance history information on 4/15/09 revealed that the survey book was missing the 2007 State survey reports. The plan of correction was missing from the 9/5/2008 Federal and State reports. Interview with facility staff confirmed this finding.	16 Del., C A) no residents were identified B) All residents have the potential to be affected by this deficient practice. C) The Administrative Assistant will monitor the survey book weekly to assure that all necessary items remain and compliance is maintained. D) An audit will be conducted weekly for the next four weeks and the results will be present in the next two QA meetings.

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16 Del. C., Chapter 11, Subchapter II, §1121	**Patient's Rights** **It is the intent of the General Assembly, and the purpose of this section, to promote the interests and well-being of the patients and residents in sanitoria, rest homes, nursing homes, boarding homes and related institutions. It is declared to be the public policy of this State that the interests of the patient shall be protected by a declaration of a patient's rights, and by requiring that all facilities treat their patients in accordance with such rights, which shall include but not be limited to the following:** **(8) Every patient and resident shall receive from the administrator or staff of the facility a courteous, timely and reasonable response to requests, and the facility shall make prompt efforts to resolve grievances. Responses to requests and grievances shall be made in writing upon written request by the patient or resident.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 4/28/09, F166.	16 Del.C., Cross Reference CMS 2567 – F166

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	(11) Every patient and resident may associate and communicate privately and without restriction with persons and groups of the patient's or resident's own choice (on the patient's or resident's own or their initiative) at any reasonable hour; may send and shall receive mail promptly and unopened; shall have access at any reasonable hour to a telephone where the patient may speak privately; and shall have access to writing instruments, stationery and postage. **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 4/28/09, F174. **(12) Each patient and resident has the right to manage the patient's or resident's financial affairs. If, by written request signed by the patient or resident, or by the guardian or representative of a patient or resident who has been adjudicated incompetent, the facility manages the patient's or resident's financial affairs, it shall have available for inspection a monthly accounting, and shall furnish the patient or resident and the patient's or**	16 Del C., Cross Reference CMS 2567 – F174

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	resident's family or representative with a quarterly statement of the patient's or resident's account. The patient and resident shall have unrestricted access to such account at reasonable hours. **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 4/28/09, F159. **§ 1141. Criminal background checks.** **(f) Conditional hire. -- Notwithstanding the provisions of subsection (c) of this section, the employer may hire or employ an applicant on a conditional basis when the employer receives evidence that the applicant has requested his or her state and federal criminal history record, and has been fingerprinted by the State Bureau of Identification. "Evidence" for purposes of this subsection shall be a verification from the State Bureau of Identification that the person has been fingerprinted and both the state and federal criminal history records have been requested.** **This requirement is not met as evidenced by:**	16 Del C., Cross reference CMS 2567 – F159

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	Cross-refer to CMS 2567-L survey date completed 4/28/09, F226. **§ 1162. Nursing staffing (a)** **Every residential health facility shall post, for each shift, the names and titles of the nursing services direct caregivers assigned to each floor, unit or wing and the nursing supervisor on duty. This information shall be conspicuously displayed in common areas of the facility, in no fewer number than the number of nursing stations.** Based on observations during the survey, it was determined the facility failed to post the complete nursing staff on duty for each shift for two of the three nursing stations of the facility, and failed to conspicuously display the posting of the staff. Observations throughout the survey revealed that the Aspen and Sierra nursing stations had the staffing posting but only contained the certified nursing assistants (CNA) information. The posting displayed lacked the nursing staffing information. The staffing posting was observed displayed on a corner across the Aspen and Sierra nursing stations that did not allow residents, visitors to easily see the information. On 4/17/09 at 10:35	1141 Cross Reference CMS 2567 – F226

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	AM, the Sierra nursing station staffing posting was observed covered by a training in-service announcement for CNAs in a corner not easily accessible to anyone. E19 interview confirmed these findings. **Title 7 DNREC, 1300 Waste Management Section** **Section 1301 Regulations Governing Solid Waste Management** **11.8.5.6 Areas used for the containment of infectious waste shall be secured so as to deny access to unauthorized persons.** Based on observation during the survey of the soiled utility room area, it was determined that the facility failed to comply with sections 1301 (11.8.5.6) of the State of Delaware Regulations Governing Solid Waste Management. **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 4/28/09, F323, Example (3) and (5).	Title 7 DNREC Cross Reference CMS 2567 – F323

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